STATE OF GEORGIA
COUNTY OF FULTON
CITY OF SOUTH FULTON

RESOLUTION NO. 2017-016

A RESOLUTION APPROVING CERTAIN CONTRACTS FOR EMPLOYEE BENEFITS

WHEREAS, the City of South Fulton ("City") is a municipal corporation duly organized and existing under the laws of the State of Georgia;

WHEREAS, through a duly enacted resolution, the City empowered the City Manager to negotiate for certain employee benefits;

WHEREAS, the City Manager has negotiated for certain employee benefits as authorized in the prior resolution;

WHEREAS, the City is authorized to employ persons to assist with City functions;

WHEREAS, to hire the best and brightest workforce for the City of South Fulton, the City should provide competitive benefits to City employees;

WHEREAS, the City Manager has negotiated for the contracts that are substantially similar to those offered by Fulton County, and the City finds the contracts to be in the best interests of City residents;

BE IT HEREBY RESOLVED by the Mayor and City Council that:

1. The aforesaid recitals are not mere recitals, but are material portions of this Resolution;

2. The Mayor is authorized to enter into the following contracts, which have been negotiated by the City Manager:

    a. Aetna Life Insurance and AD&D Insurance Plan (Exhibit 1);

    b. Kaiser Permanente Health Maintenance Organization Plan option (Exhibit 2); and

    c. Blue Cross Blue Shield Open Access POS option (Exhibit 3); and

    d. EyeMed Vision Care option (Exhibit 4).

The foregoing Resolution No. **2017-016** was offered by Councilmember **Willis,** who moved its approval. The motion was seconded by Councilmember **Baker,** and being put to a vote, the result was as follows:

	AYE	NAY
William "Bill" Edwards, Mayor		
Catherine Foster Rowell, Mayor Pro Tem	√	
Carmalitha Lizandra Gumbs	√	
Helen Zenobia Willis	√	
Gertrude Naeema Gilyard	√	
Rosie Jackson	√	
khalid kamau	√	
Mark Baker	√	

THIS RESOLUTION adopted this 13th day of June 2017. **CITY OF SOUTH FULTON, GEORGIA**

WILLIAM "BILL" EDWARDS, MAYOR

ATTEST:

MARK MASSEY, CITY CLERK

CITY OF SOUTH FULTON SEAL 2017 GEORGIA

APPROVED AS TO FORM:

JOSH BELINFANTE, INTERIM CITY ATTORNEY

DIVIDER SHEET

aetna™

Employer Application

Applicant

Policy or Group Number (for Aetna use only)

Company Name: City of South Fulton

Street Address: 5440 Fulton Industrial Boulevard

City: Atlanta State: GA Zip Code: 30336

Federal Tax ID Number: 82-137484

Parent Company name (if applicable)

The purpose of the application is to request:

a. [x] issuance of new coverage
b. [ ] change in existing coverage
c. [ ] extension of existing coverage to additional groups of employees

Medical Coverage Selection: Provided or administered by Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health Inc., and/or Aetna Health Insurance Company.

If offering a health plan with a deductible, is the employer, plan sponsor or a third party funding any of the deductible?

[ ] Yes*
[ ] No

*If yes, how much?

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	[ ]	[ ]	[ ]	Medical
Non-Contributory	[ ]	[ ]	[ ]	

Stand-Alone Aetna Vision Preferred Coverage Selection: Provided or administered by Aetna Life Insurance Company.

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	[ ]	[ ]	[ ]	Aetna Vision Preferred
Non-Contributory	[ ]	[ ]	[ ]	

Stand-Alone Dental Coverage Selection: Provided or administered by Aetna Health Inc., Aetna Dental Inc., Aetna Dental of California Inc., and/or Aetna Life Insurance Company.

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	[x]	[xx]	[ ]	Dental Coverage
Non-Contributory	[ ]	[ ]	[ ]	

Life & Disability: Provided or Administered by Aetna Life Insurance Company

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	[x]	[x]	[ ]	Basic Term Life Insurance
Non-Contributory	[ ]	[ ]	[ ]	Dependents' Maximum subject to state law
Contributory	[x]	[x]	[ ]	Supplemental Term Life Insurance
Non-Contributory	[ ]	[ ]	[ ]	Dependents' Maximum subject to state law
Contributory	[x]	[x]	Not	Accidental Death & Personal Loss Coverage
Non-Contributory	[ ]	[ ]	Available	
Contributory	[ ]	[ ]	Not	Supplemental Accidental Death & Personal Loss Coverage
Non-Contributory	[ ]	[ ]	Available	
Contributory	[ ]	Not	Not	Long Term Disability
Non-Contributory	[x]	Available	Available	
Contributory	[ ]	Not	Not	Short Term Disability
Non-Contributory	[ ]	Available	Available	
Contributory	[ ]	[ ]	[ ]	Other:
Non-Contributory	[ ]	[ ]	[ ]	

General enrollment and eligibility section

Requested effective date: 7/1/2017 (Actual effective date will be assigned by Aetna if the application is accepted and a policy issued.)

Applicant will utilize electronic enrollment (check one): [x] Yes [ ] No

This application includes the following member employers.
(Any entry in conflict with applicable law cannot be included): Additional sheets may be added if necessary.

_____ Located At _____

_____ Located At _____

_____ Located At _____

All regular full-time employees and all regular part-time employees regularly scheduled to work at least 20 hours or more per week shall be eligible to participate as to the coverage hereby applied for, except the following (state here, by coverage, the class or classes excluded.) If more space is needed, please attach an additional sheet.

_____

Agent(s) of Record: N/A

Name: N/A Signature: _____ License #: _____

General Agent Name: _____ Signature: _____ License #: _____

Applicant Acknowledgements and Agreements

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. With the exception of Arizona (refer to group applicant paragraph below), it is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically agreed to by Aetna and provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected the coverage specified herein based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Policy and/or Group Agreement available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Policy and/or Group Agreement.

Applicant has selected, in accordance with applicable state law, the coverage to be offered to Applicant's employees and Applicant has solely determined any/all coverage options for the Applicant's employees and the contribution amounts. The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the coverage and will govern in the event they conflict with any benefits comparison, summary or other description of the coverage. (Does not apply to Applicants in Illinois, Kansas and Missouri). Oklahoma Group Applicants: Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member and are in compliance with Oklahoma law. See below for applicable provisions.

Applicant Acknowledgements and Agreements (Continued)

With the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

Applicant agrees to deliver or otherwise make available to enrollees all Aetna paper or on-line member documents and other plan related materials upon request by Aetna.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement and/or Group Policy is in force. The availability of a plan or program may vary by geographic service area.
"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

ARIZONA GROUP APPLICANTS: Eligibility requirements for active employees will be determined by the employer as stated in the Terms and Charges of the proposal. The information, as well as other personal and privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Arizona law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.

KANSAS, ILLINOIS & MISSOURI GROUP APPLICANTS: The Group Agreement and/or Group Policy will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the form. Any direct conflict between this form and the Group Agreement and/or Group Policy will be resolved according to the terms which are most favorable to the member.

aetna®

City of South Fulton
Effective Date: 07-01-2017

Dental Benefits Summary

	DMO
Annual Deductible	
Individual	None
Family	None
Preventive Services	100%
Basic Services	100%
Major Services	60%
Annual Benefit Maximum	None
Office Visit Copay	$0
Orthodontic Services (Adult and Child)	$1,500 copay
Orthodontic Deductible	None
Orthodontic Lifetime Maximum	***

*** 24 months of comprehensive orthodontic treatment plus 24 months of retention

Partial List of Services	DMO
Preventive	
Oral examinations (a)	100%
Cleanings (a) Adult/Child	100%
Fluoride (a)	100%
Sealants (permanent molars only) (a)	100%
Bitewing Images (a)	100%
Full mouth series Images (a)	100%
Space Maintainers	100%
Basic	
Root canal therapy	
Anterior teeth / Bicuspid teeth	100%
Scaling and root planing (a)	100%
Gingivectomy*	100%
Amalgam (silver) fillings	100%
Composite fillings (anterior teeth only)	100%
Stainless steel crowns	100%
Incision and drainage of abscess*	100%
Uncomplicated extractions	100%
Surgical removal of erupted tooth*	100%
Surgical removal of impacted tooth (soft tissue)*	100%
Major	
Inlays	60%
Onlays	60%
Crowns	60%
Full & partial dentures	60%
Pontics	60%
Root canal therapy, molar teeth	60%
Osseous surgery (a)*	60%
Surgical removal of impacted tooth (partial bony/ full bony)*	60%
General anesthesia/intravenous sedation*	60%
Denture repairs	60%
Crown Lengthening	60%
Crown Build-Ups	60%

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

X _____
Mayor William "Bill" Edwards

Prepared: 06/08/2017 01:55 PM

aetna®

City of South Futlon
Effective Date: 07-01-2017

Dental Benefits Summary

	Active PPO With PPOII Network	
	Participating	Non-participating
Annual Deductible*		
Individual	$50	$50
Family	$150	$150
Preventive Services	100%	100%
Basic Services	85%	85%
Major Services	50%	50%
Annual Benefit Maximum	$1,500	$1,500
Office Visit Copay	N/A	N/A
Orthodontic Services (Adult and Child)	50%	50%
Orthodontic Deductible	$50	$50
Orthodontic Lifetime Maximum	$1,500	$1,500
*The deductible applies to: Basic & Major services only		

Partial List of Services	Active PPO With PPOII Network	
Preventive	Participating	Non-participating
Oral examinations (a)	100%	100%
Cleanings (a) Adult/Child	100%	100%
Fluoride (a)	100%	100%
Sealants (permanent molars only) (a)	100%	100%
Bitewing Images (a)	100%	100%
Full mouth series Images (a)	100%	100%
Space Maintainers	100%	100%
Basic		
Root canal therapy		
Anterior teeth / Bicuspid teeth	85%	85%
Scaling and root planing (a)	85%	85%
Gingivectomy*	85%	85%
Amalgam (silver) fillings	85%	85%
Composite fillings (anterior teeth only)	85%	85%
Stainless steel crowns	85%	85%
Incision and drainage of abscess*	85%	85%
Uncomplicated extractions	85%	85%
Surgical removal of erupted tooth*	85%	85%
Surgical removal of impacted tooth (soft tissue)*	85%	85%
Major		
Inlays	50%	50%
Onlays	50%	50%
Crowns	50%	50%
Crown lengthening	50%	50%
Full & partial dentures	50%	50%
Pontics	50%	50%
Root canal therapy, molar teeth	50%	50%
Osseous surgery (a)*	50%	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	50%	50%
General anesthesia/intravenous sedation*	50%	50%
Denture repairs	50%	50%
Crown Build-Ups	50%	50%

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Mayor William "Bill" Edwards

Prepared: 06/08/2017 02:00 PM

Dental Dual Option Rate Exhibit - DMO/DPPO
July 1, 2017 through June 30 2018, Mature

Total Enrollment from Census: 410

Dual Option

Fully-Insured DMO®		
Plan Design		100/100/60
Office Visit Copay		$0
Plan Maximum		None
Plan Deductible		None
Orthodontia Plan Design	Adult/Child	$1500 Copay
Orthodontia Deductible		None
Orthodontia Maximum		None

Tier	Lives	Rates
Employee	56	$14.82
Employee + Dependent	31	$34.49
Family	56	$54.16
Total	143	$4,932.07

Fully-Insured DPPO	In-Network	Out of Network
Plan Design	100/85/50	100/85/50
Plan Maximum	$1,500	$1,500
Individual Deductible	$50	$50
Family Deductible	$150	$150
Prev. Services Deductible	None	None
Orthodontia Plan Design	50% Adult/ Child	50% Adult/Child
Orthodontia Deductible	$50	$50
Orthodontia Maximum	$1,500	$1,500
* Osseous Surgery, Impactions, General Anesthesia & MRCT included under Basic		

Tier	Lives	Rates
Employee	106	$29.42
Employee + Dependent	57	$66.78
Family	104	$104.14
Total	267	$17,755.54

Assumptions:

* 80th percentile R&C for out-of-network coverage for the DPPO plans.
* Aetna will be offered as full replacement.
* Commissions are excluded in the above rates.

Additional Comments:

* Rates may be adjusted if:
  - legislation or regulation is enacted that affect the benefits payable, eligibility or contractual provisions;
  - there is any other material change in the condition under which the plan operates.

Mayor William "Bill" Edwards

The Patient Protection and Affordable Care Act imposes a Health Insurer Fee (the "Fee"). The Fee became effective on January 1, 2014. The Fee will be suspended for 2017, but reinstated starting in 2018. This rate quote includes, where permitted, the estimated proportionate allocation of the Fee for the years where the Fee is applicable.

Please refer to the Financial Information section for a detailed description of our rate guarantee and the assumptions used by Aetna in developing our financial offer.

Important Information

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ARIZONA HMO APPLICANTS: I understand that if it is determined that I have committed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, my company's group health coverage may be terminated or my company may be charged a different premium for this coverage.

COLORADO GROUP APPLICANTS: Please see the Colorado Disclosures attachment.

CALIFORNIA, OHIO & PENNSYLVANIA CONTRACT SITUS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MAINE & TENNESSEE CONTRACT SITUS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

OHIO HMO APPLICANTS: Any Group may cancel a signed agreement within seventy-two hours after having signed the agreement to enroll under this plan. Cancellation occurs when written notice of the cancellation is given to the HMO or its agents or other representatives. A notice of cancellation mailed to the HMO shall be considered to have been filed on its postmark date.

KENTUCKY CONTRACT SITUS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil

Important Information (Continued)

CALIFORNIA NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

CALIFORNIA HMO APPLICANTS: Any dispute arising from or related to the Group Agreement will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by the Group Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. This agreement also limits certain remedies and may limit the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of the Evidence of Coverage for further Information.

The undersigned representative of the Employer understands that the Employer and any Groups eligible through the Employer, if different from the Employer, and any Members who enroll under this health plan are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that the Employer, Groups, Members and other interested parties will not be able to try their case in court. The undersigned representative of the Employer further understands and accepts that the Employer, Groups and Members are giving up certain remedies and that there may be certain limitations to the recovery of punitive damages.

Signature Section

I hereby apply for the coverage(s) indicated above. *I certify that all information provided in this application is accurate and complete. *NEW HAMPSHIRE APPLICANTS, I represent that all information provided in this application is accurate and complete. I understand that this application will form a part of the Group Agreement and/or Group Policy issued by Aetna and by my signature below I agree to be bound by the terms and conditions of that Group Agreement and/or Group Policy. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any state requirements.

Signed at (location): Atlanta, Georgia
City, State

By: [signature]
Authorized Applicant Signature

[signature]
Witness

City of South Fulton
Applicant (Company Name)

MAYOR
Official Title

06/20/2017
Date

Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-appointed licensed independent agent or broker identified in the Application For Group Coverage. Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's programs for compensating producers is also available at www.aetna.com. **We appreciate your business and the opportunity to serve you.**

Please keep a copy of this application for your records. If the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.

aetna

Electronic Enrollment, Billing/Payment and Access Agreement

The purpose of this Agreement is to direct Aetna to accept your electronic enrollment data and payment transactions and to outline online billing and access requirements via certain electronic interfaces that Aetna makes available to customers.

Aetna strives to provide the highest level of accuracy in the information provided in its system; however, information in the system is not guaranteed.

Access

Plan sponsor agrees that each employee will agree to terms associated with the issuance and use of his/her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

Enrollment

As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and/or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Aetna upon request and retained for seven years.

2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.

3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.

4. Insured plans must either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.

   - Names(s) of the Aetna company offering the insurance coverage
   - State-specific fraud warning statement
   - A statement that the terms of the insurance documents will govern the member's rights and responsibilities
   - An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change

   NOTE: Please see insured template language attached.

5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Aetna.

6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing

You agree to receive your bill online each month.

Any contractual provisions related to non-payment of premium continue to be applicable.

I/we understand and agree to the terms set forth in this Agreement. By signing below, I represent that I am authorized to sign this Agreement.

Customer Signature	City of South Fulton Company Name
William Edwards, Mayor Name (Printed), Title	06/20/2017 Date

Template Language for Insured Enrollment Material

1. I understand that coverage is being provided by the following companies:
   Traditional Choice®, Open Choice® and Managed Choice®: Aetna Life Insurance Company
   Life, Accidental Death & Personal Loss, Disability: Aetna Life Insurance Company
   HMO, QPOS®: Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Corporate Health Insurance Company
   Dental: Aetna Life Insurance Company, Aetna Health Inc., Aetna Dental Inc., Aetna Dental of California Inc.

2. The plan documents (Schedule of Benefits, Group Agreement, Group Policy and Certificate of Coverage) will determine my rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan.

3. I understand and agree that with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular product cannot be guaranteed, and provider network composition is subject to change.

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DIVIDER SHEET

EMPLOYER GROUP MASTER APPLICATION

For groups with 51 or more eligible employees

Kaiser Permanente Insurance Company (KPIC)

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

603C6008 03/15

KAISER PERMANENTE®

Employer Information

The information requested on this application is necessary for purposes of processing your request for group coverage, and verifying the appropriateness of final rates. **Please Note:** Statements made in application form are deemed representations and are not warranties.

Employer Legal Name	**HR Contact Name**	**Date Prepared**
City of South Fulton	Anquilla Henderson	05/18/2017

DBA (if applicable)			
Address 5440 Fulton Industrial Blvd		**Phone** 404-612-7800	**Fax** 404 612 2226
City Atlanta	**State** GA	**ZIP** 30336	**E-Mail Address** anquilla.henderson@cityofsouthfultonga.gov
Address of Organization's Headquarters 5440 Fulton Industrial Blvd			
City Atlanta	**State** GA	**ZIP** 30336	
SIC Code and Nature of Business or Industry 9199	**# of Locations** 1	**Tax Id #** 82 1371813	**Coverage Effective Date** 06/01/2017 5/1/17

Are all of the Kaiser Permanente subscribers in your group associated with the same EIN/TIN? ☒ Yes ☐ No	If you do not have a federal EIN/TIN, are you a foreign-owned organization? ☐ Yes ☐ No

Total Number of Eligible Employees (including those waiving coverage) 200	**Eligible Employees** ☒ Full-Time (30 hrs per week) ☐ Other	**Annual Renewal Date** 06/01/2017 → 1/1/2018

Excluded from Eligibility ☐ Retirees ☐ Others

Is there a single address where all Coordination of Benefits issues and questions should be directed? ☐ Yes ☒ No

If yes, please provide that address (if different from address of headquarters address).

Address		**Phone**	**Fax**
City	**State**	**ZIP**	

Type of Organization (check all that apply): ☐ State government ☐ Publicly traded corporation ☐ Church group ☐ Other ☒ Local government ☐ Privately held corporation ☐ Non-profit

Is your organization a Taft-Hartley, Hours Bank, or multi-employer organization? ☐ Yes ☒ No

Type of Group Plan Sponsor (check one): ☒ Employer ☐ Labor organization ☐ Trustees of a fund established by one or more employers or labor organizations

Group Size – Total Number of Full and/or Part-time Employees (check one): Please select the largest applicable category. In making your selection, consider your organization/company's total number of employees world-wide, regardless of location or eligibility for health care coverage.

☐ 20-99 full and/or part-time employees for 20 or more weeks of either the current or the prior calendar year

☒ 100 or more full and/or part-time employees for 50 percent or more of your regular business days during the prior calendar year

KM 5/23/17

KM

Billing Information

Billing Contact			☒ Same As Group Contact
Address		Phone	Fax
City	State	ZIP	E-Mail Address

Important Notice: The employer is responsible for determining on a monthly basis whether an individual satisfies the definition of eligible employee, as stated on the Employer Group Master Application. To be eligible, an employee must work for this employer or be on paid leave through this employer for the minimum number of full-time hours stated on this application.

Plan Selection

For additional benefit selection information, refer to the attached plan summaries. Please review the summaries for all plans purchased and make your selections in the chart below.

Business Offering:	**Plan Type** Check Box:		**KPMP:**
☐ Sole Carrier	☐ Signature HMO	☐ Out-of-Area PPO	☐ Basic
☒ Slice	☒ HMO	☐ HSA-Qualified Deductible Plan	☐ Comprehensive
☐ Single Option	☐ Multi-Choice	☐ Deductible Plan With HRA	☐ Standard
☐ Dual Option	☐ Senior Advantage*		☐ Senior Advantage
☐ Triple Option	* Certain Minimum Benefits Apply.		

Is this coverage replacing other insurance coverage? ☐ Yes ☒ No If so, name of carrier being replaced: _____

HMO plans (including Deductible Plans), Senior Advantage, and the Select Provider benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan). The PPO Provider and Non-participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company (KPIC).

Consumer Choice Option (CCO) Enrollment
Have any of your employees opted for the CCO option? ☐ Yes ☒ No

If yes, additional premium collected by: ☐ Employer deduction from employee paycheck ☐ Kaiser Permanente bills the employee

Administrative

Annual Enrollment Period From To	**Positive Enrollment** (election required)	☐ Yes ☒ No	**Ongoing Enrollment Method** ☒ Paper Application ☐ Tape ☐ CAS (Please fill out application)
Account Structure We can set up separate bill groups when you require premium to be allocated and reconciled by division or department. Do you require separate bill groups?		☐ Yes ☒ No	
Bill Group Name 001 City of South Fulton			
Bill Group Name			
Bill Group Name			

Deductible and Out of Pocket Maximum Accumulations

Choose Your Accumulation type: ☒ Calendar Year (Customary; January 1 -December 1) ☐ Plan Year

If Plan Year, select the start month of accumulation: ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEP ☐ OCT ☐ NOV ☐ DEC

Group Health Status

To the best of your knowledge, have any employees or dependents of employees been diagnosed or treated during the past 24 months for a serious health problem such as Acquired Immunodeficiency Syndrome (AIDS); Human Immunodeficiency Virus (HIV) Positive Status; Alzheimer's Disease; Cancer; Diabetes; Heart Disease; Hemophilia; Liver Disease; Kidney Disease; Mental Illness; or Substance Abuse?

☐ Yes ☒ No If yes, provide details below.

Patient Age	Sex	Relationship To Employee	Claim Amount	MM/YY of Treatment	Condition	Degree of Recovery
1.					information previously provided has not changed	
2.						
3.						
4.						

Has anyone within the past 12 months been hospitalized, institutionalized, or missed work due to disability or injury?

☐ Yes ☒ No If yes, provide details below.

Patient Age	Sex	Relationship To Employee	Claim Amount	MM/YY of Treatment	Condition	Degree of Recovery
1.					information previously provided has not changed	
2.						
3.						
4.						

Monthly Premium Contributions

Write the Kaiser Permanente plan type (i.e., HMO, Multi-Choice, etc.) in the top row, and the percentage contributions for that plan type in the rows below it.

Plan Type:					
HMO	%	%	%	%	%
Employee Only	80				
Employee + Child					
Employee + Spouse					
Employee + One	80				
Employee + Children					
Family	80				

Additional Carrier
If another carrier is offered along with Kaiser Permanente, please complete the following. (If more than one additional carrier, attach another sheet.)
BCBS (POS & HSA)

Carrier Name

Plan(s) Offered: ☐ HMO ☐ PPO ☒ POS
Funding Arrangement: ☐ Fully Insured ☒ Self-Funded

Write the plan type (i.e., HMO, Multi-Choice, etc.) in the top row, and the rates and percentage contributions for that plan type in the rows below it.

Plan Type:						
	Rate	%	Rate	%	Rate	%
Employee Only						
Employee + Child						
Employee + Spouse						
Employee + One						
Employee + Children						
Family						

Employer Information

Employer acknowledges that this plan constitutes an employee welfare benefit plan and agrees, as "sponsor", to fully comply with the applicable provisions and requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Employer designates Health Plan and/or KPIC, as applicable, as the named fiduciary for claims and appeals arising under the Group Agreement and/or Group Policy, as applicable. Neither Health Plan nor KPIC is the administrator of employer's employee benefit plan as that term is defined under ERISA.

This provision only applies to an employer who sponsors an employee welfare benefit plan covered by ERISA, and where Health Plan's and/or KPIC's group health coverage is a component of that employee welfare benefit plan.

Group represents and warrants that Group complies with eligibility requirements, pursuant to applicable federal and state law, directly and indirectly related to the group health plan including but not limited to those pertaining to waiting periods and orientation periods.

In addition, Group agrees that enrollment data provided by the Group to Health Plan will include coverage effective dates for Group's employees and dependents in accordance with all group health plan eligibility requirements including but not limited to those associated with waiting periods and orientation periods.

I understand and agree, on behalf of the employer, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that this Application and my answers (a) will become part of any Group Agreement which may ultimately be issued by Health Plan; (b) will become part of any Group Policy which may ultimately be issued by KPIC; and (c) are made to induce Health Plan and/or KPIC, as applicable, to issue the group coverage(s) as applied for.

Any intentional material misstatement or omission of information made on this application will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information, without liability to Health Plan, KPIC, and The Southeast Permanente Medical Group, Inc.

Signed this 18th day of May City Atlanta State GA

Frank S. Milazi — By (Signature of Authorized Company Officer)

CFO — Title

Premium deposit collected: $ _____

Broker Designation: I hereby designate _____ (Broker Name) as the broker of record.

Signature of Authorized Company Officer — Date

Broker Information

☐ (Please check box if this is to replace address currently on file.)

Writing Broker's Name

Street Address

Area Code Telephone Number

Fax

Mailing Address

City State ZIP

Social Security Number or Tax I.D. Number

Broker's E-mail Address

Broker's License: State License Number

Broker's Statement:

To the best of my knowledge and belief, all medical history, employment, and other information supplied in this group application is true and complete. I acknowledge that I represent and am acting on behalf of my client and not for or as an employee of Kaiser Foundation Health Plan, Inc. or KPIC. I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved. I understand that I have no right to bind this coverage, or to alter terms of the insurance concerning incomplete or additional underwriting information.

By (Writing Broker's Signature)

Date Month/Day/Year

General Agent Stamp

Underwriting Requirements and Assumptions

The proposed rates that accompany this document are not final until you sign your Group Agreement and/or Group Policy, as applicable verifying the terms of your agreement with us, including the conditions of offering and any changes for the contract year, or until you pay any portion of the Monthly Membership Charges for the contract year. These proposed rates are based on the terms and conditions listed below unless explicitly stated otherwise in the Rate Proposal. If you fail to meet any of the Underwriting Requirements and Assumptions at any time, we may withdraw our rate proposal, re-rate or terminate your Group Agreement and/or Group Policy.

- The rates are valid for a 12-month period following the effective date unless explicitly stated otherwise or if either of the following events occur:
  - A government agency or other taxing authority imposes or increases a tax or other charge (excluding a tax on or measured by net income) upon Health Plan, Medical Group or its physicians, or Kaiser Foundation Hospitals (or any of our activities).
  - There is a cost associated in complying with newly enacted legislation. Then beginning on the effective date of that tax, charge, or legislation, we may calculate your rates to include your share of the new or increased tax or charge or cost of legislative compliance.
- Minimum Contribution, Participation, and other Group Requirements:
  - The greater of five or 5 percent of the active, eligible employee subscribers must be enrolled in our plan if we are offered alongside another carrier.
  - At least 75 percent of all eligible employees must enroll in the group health plans offered by the employer.
  - All eligible employees must work at least 20 hours per week.
  - Contributions must be at least 50 percent of the employee-only rate.
  - There must be a bona fide employer/employee relationship between the employee and all eligible employees offered our plan with the exception of eligible Taft-Hartley trusts and partnerships.
  - 100 percent of your eligible employees must be covered by Worker's Compensation, unless not required by law to be covered.
- The contracting employer must offer enrollment in this plan to employees on conditions that are no less favorable than those for any other plan that the employer makes available. A few examples include, but are not limited to, the following:
  - Employer must offer our plan to all eligible employees.
  - We must have equal access to you and your employees as all other plans offered.
  - The employer must not have a discriminatory contribution arrangement that is unfair to us. For example, an acceptable formula includes one in which you apply a uniform equal dollar employer contribution, or an equal percentage contribution.
  - Basic and optional benefits, such as prescription drugs and infertility, must be comparable among all plans offered.
  - When domestic partner coverage is provided, it must be provided on the same basis for all plans.
  - The rate ratios of the plans offered must be aligned. The rate steps (and their definitions) of the plans offered must be uniform.
  - If early retirees are covered, the employer must offer all plans to early retirees on the same basis. The eligibility rules (e.g., dependent age limits and waiting periods for new hires) must be consistent across all plans.
  - The employer will not allow any preferential treatment to be given to another plan offered.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement, Group Policy, Evidence of Coverage, and/or Certificate of Insurance, as applicable.

Employer

By: Ruth C. Jones

Title: Interim City Manager (Authorized Company Officer)

Date: 05/18/2017

DIVIDER SHEET

BlueCross BlueShield of Georgia

BlueCross BlueShield Healthcare Plan of Georgia

Greater Georgia Life Insurance Company

Employer Enrollment Application
For 51+ Eligible Employee Groups
Georgia

The purpose of this form is for Blue Cross and Blue Shield of Georgia, Inc. (BCBSGa), Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) and Greater Georgia Life (GGL) to evaluate rating for the company's request for group insurance coverage. Please answer all questions. This form must be signed and dated by an officer of the company.

Group no.
G A 9 4 7 2

Please complete electronically, or in blue or black ink only.

Section A: Company Information

☑ New enrollment ☐ Renewal/Plan amendment	Benefit year ☑ Calendar ☐ Other:	Effective date (MM/DD/YYYY) 0 7 0 1 2 0 1 7

Company name	Employer tax ID no. (required)
C i t y o f S o u t h F u l t o n	8 2 - 1 3 7 4 8 4

Company street address
5 4 4 0 F u l t o n I n d u s t r i a l B o u l e v a r d

City	County	State	ZIP code
A t l a n t a	F u l t o n	G A	3 0 3 3 6

Billing address – if different from above			
City	County	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☑ Government unit/agency ☐ Limited Liability Company (LLC) ☐ Labor union trust ☐ Other	SIC code
	9 1 1 1

Group administrator name	Primary phone no.
R u t h J o n e s	6 1 7 7 5 6 8 9 9 4

Email address
r u t h . j o n e s @ c i t y o f s o u t h f u l t o n g a . g o v

Additional company contact name	Primary phone no.

Email address

Current group carrier	Current carrier effective date	Type of coverage	Type of funding
BCBSGA	0 1 0 1 2 0 1 7	Medical	ASO

If enrolling employees from a subsidiary, complete the following:

Name of subsidiary	Nature of business		
Street address	City	State	ZIP code

Group no.
G A 9 4 7 2

Section B: Type of Coverage

1. Medical Coverage – Please list the selected product name

PPO Plans

Product name		
1.	2.	3.

POS Plans

Product name		
1. NS OAP5 500 10 2k A	2. NS HSAOAP8 2.6k 20	3.

HMO Plans

Product name		
1.	2.	3.

Choose your medical contribution for each month – only **one** choice is allowed.

Contribution option 1: Traditional option – Group will contribute (50% to 100%): 80 % per employee 80 % per dependent (optional).

Contribution option 2: Percentage of plan option – Group will contribute: 75 % to POS Plan plan.

Contribution option 3: Flat rate per month option – Group will make a once-a-month contribution of $ _____.

For CDHP Accounts (HSA/HRA) plans:

☑ Group will establish HSA/HRA with BCBSGa facilitating with a banking services provider.
HSA/HRA banking services provider: Health Equity

☐ Group will establish HSA/HRA but does not want BCBSGa to facilitate in the creation of the account.

If CDHP plan is elected, is employer funding all/part of the member's deductible? ☐ Yes ☐ No

If deviating from standard benefits in plan, please provide specific benefit change requests:

2. Dental Coverage – Please list the selected product name

Product name		
1.	2.	3.

Choose your dental contribution for each month

_____% per employee _____% per dependent (optional) Flat rate option: $ _____

Will the coverage period for deductibles and maximums match the medical coverage? ☐ Yes ☐ No

If no, please provide coverage period (calendar or plan year): _____

Will ortho benefits terminate at the end of the month of dependent's 19th birthday? ☐ Yes ☐ No

3. Vision Coverage – Please list the selected product name

Product name		
1.	2.	3.

Choose your vision contribution for each month

_____% per employee _____% per dependent (optional) Flat rate option: $ _____

Group no.
GA9472

4. Life and Disability Coverage – check all that apply.

Life Products		Disability Products	
Choose Life Product and Group Contribution Percentage:		**Choose Disability Product and Group Contribution Percentage:**	
☑ None		☑ None	
☐ Basic Life & AD&D	_____%	☐ Short Term Disability	_____%
☐ Basic Dependent Life	_____%	☐ Long Term Disability	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long Term Disability*	_____%

Do employees need to be enrolled in the group's medical plan to be eligible for Life/Disability benefits? ☐ Yes ☐ No

STD benefits for employees eligible for state disability plans in CA, HI, NJ, NY, PR or RI will be integrated with the state mandated program in that state. The volume calculated for monthly premium will be based on the total benefit amount, and not reduced by the state mandated benefit.

Life and/or Disability Probationary Period/Waiting Period

Would you like to waive the probationary period/eligibility waiting period for ALL existing employees at intitial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in Life and/or Disability plans after the group's coverage effective date the same as the BCBSGa medical policy eligibility period? ☐ Yes ☐ No

If no, enter the Life and Disability eligibility probationary period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

Prior Coverage

Has this group had life and/or disability coverage within 30 days of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name	Termination date
Life coverage ☐ Yes ☐ No		
Disability coverage ☐ Yes ☐ No		

Group no.
G A 9 4 7 2

Not Actively At Work Requirements for Life & Disability Products

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Greater Georgia Life Insurance Company (GGL) may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to GGL's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under GGL's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Employee name	Amount of insurance	Date of birth	Last date worked	Reason not working	Date expected to return	Insured by prior carrier	Request actively at work waiver	Waiver request approved	Underwriter approval
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Section C: Eligibility

1. Total number of employees (including employed owners/officers): 187
2. Number of eligible full-time employees (minimum 30 hours per week): 187
3. Are part-time employees to be covered? ☐ Yes ☑ No
   If yes, number of part-time employees: _____
   Number of eligible part-time: _____
   Number of enrolled part-time: _____
4. Are retirees to be covered? ☐ Yes ☑ No
   If yes, number of retirees over the age of 65: _____
   under the age of 65: _____
5. Number of employees enrolling in:
   Medical: 187 Dental: _____
   Vision: _____ Life/ Disability: _____
6. Number of employees currently enrolled in health plan: 187
7. Number of eligible DECLINING employees: _____
8. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? ☑ Yes ☐ No
   If yes, please explain what class(es) or number of work hours are required (must be at least 30 hours)
   wp is 1st of the mon. that has 2 pay period
9. Probationary period/waiting period for **eligible enrollees**:
   ☐ None ☑ First of month after hire date ☐ 1 month
   ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days
10. New eligible enrollees will become effective on:
    ☑ Day following completion of waiting period/probationary periods **(required for selection of 90 day waiting period)**
    ☐ First of month following completion of waiting period/ probationary period
11. Total number of employees in employee waiting period: _____
12. Do you wish to offer coverage for domestic partners? ☐ Yes ☑ No
13. Total number of COBRA participants: _____
14. Will BCBSGa be administering COBRA? ☑ Yes ☐ No
15. ERISA qualified? ☐ Yes ☑ No
16. Employee termination effective date:
    ☑ End of month ☐ End of day

Section D: Signature – Required

The proposed Effective Date of the Group Master Contract or Amendment, if issued, is 12:01 a.m. (Eastern Time) on the 1st day of July (month), 2017 (year).

The first Contract anniversary date shall be on the 1 day of January (month), 2018 (year) whether or not the two dates are separated by twelve (12) months. The Group Master Contract or Amendment, if issued shall remain in force unless terminated in accordance with the terms of the Group Master Contract or Amendment. The premium due date shall be the first of each month.

Signature of employer's authorized representative	Printed name of employer's authorized representative	Date (MM/DD/YYYY)
X William Edwards	William Edwards	06 20 2017

Group no.
GA9472

Section E: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize BCBSGa to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until BCBSGa reviews and approved the application and the employer receives a written notice from BCBSGa.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from BCBSGa shall be paid to an agent/broker/producer not appointed/approved by BCBSGa.
6. I have advised the client not to terminate any existing coverage until receiving written notification from BCBSGa that the coverage being applied for by this application is accepted.

Are commissions paid to the agent or agency? ☐ Agent ☐ Agency

Writing payable/sub-agent/producer/broker			**Second writing payable/sub-agent/producer/broker**		
Split commission percentages: Medical: 0 % Dental: ____ %			Split commission percentages: Medical: ____ % Dental: ____ %		
Agency name	Agency ID no.		Agency name	Agency ID no.	
Agent/producer/broker name	Agent ID no.		Agent/producer/broker name	Agent ID no.	
Commissions paid to Tax ID (must match designation above)			Commissions paid to Tax ID (must match designation above)		
Agent/producer/broker street address			Agent/producer/broker street address		
City	State	ZIP code	City	State	ZIP code
Agent/producer/broker phone no.			Agent/producer/broker phone no.		
Agent/producer/broker email address			Agent/producer/broker email address		
Signature	Date (MM/DD/YYYY)		Signature	Date (MM/DD/YYYY)	

For General Agent/Producer/Broker use only

General agent/producer/broker name	Agent/producer/broker ID no.		
Street address	City	State	ZIP code

Sales Representative

Sales representative name	Sales representative ID no.
Tarsha Johnson	2059

BCBSGA USE ONLY

Group no.	PEPM: ____ Commission rates for: Medical: ____ Life: ____ Dental: ____ Vision: ____	Funding type change? ☐ Yes ☐ No Platform change? ☐ Yes ☐ No If yes, what was the prior group number? ____

DIVIDER SHEET

City of South Fulton
EyeMed Select Plan G, Fixed Fee
Mixed Contribution
Option 2
EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Version 7

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$0 Copay	$50
Retinal Imaging Benefit	Up to $39	N/A
Exam Options: Standard Contact Lens Fit and Follow-Up: Premium Contact Lens Fit and Follow-Up:	 Up to $40 10% off Retail Price	 N/A N/A
Frames, Lens & Options Package: (Any frame, lens and lens options available at provider location.)	$200 Allowance for frame, lens and lens options, 20% off balance over $200	$100
Contact Lenses *(Includes materials only)* Conventional Disposable Medically Necessary	 $0 Copay; $200 allowance, 15% off balance over $200 $0 Copay; $200 allowance, plus balance over $200 $0 Copay, Paid-in-Full	 $160 $160 $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency: Examination Frame & Lenses or Contact Lenses	 Once every 12 months Once every 12 months	
Monthly Rate Subscriber Subscriber + 1 Subscriber + Family	 $10.17 $19.31 $28.36	

All plans are based on a 30 month contract term and a 30 month rate guarantee
Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group
Rates are valid for groups domiciled in the State of GA.
Fees quoted will be valid until the 7/1/2017 plan implementation date. Date quoted: 6/9/2017.
Rates assume Mixed
Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York
Policy number VC-19/VC-20, form number M-9083

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If City of South Fulton has chosen this benefit design, sign here:

Signature

Date 6/20/2017

TCO

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company

Kansas City, Missouri

I. GROUP INFORMATION

Group Name: CITY OF SOUTH FULTON GEORGIA Tax ID#: 82-137484

DBA Name (If other than above):

Business Address: 5440 FULTON INDUSTRIAL BLVD SW City ATLANTA State: GA ZIP: 30336

Mailing Address: 5440 FULTON INDUSTRIAL BLVD SW City ATLANTA State: GA ZIP: 30336

Primary Contact: ZINA COOPER Title: HUMAN RESOURCES MANAGER

Phone Number: (470) 809-7722 Fax Number: ( )

E-mail Address: ZINA.COOPER@CITYOFSOUTHFULTONGA.GOV

Type of Business: ☐ Proprietorship ☐ Corporation ■ Other (Specify): CITY GOVERNMENT

Service Area: ☐ National (United States – does not include Puerto Rico) ■ State Specific (List) GEORGIA

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the business address above, please explain.

Billing Contact Name: FELICIA JOHNSON Phone: (470) 809-7708

Billing Address: 5440 FULTON INDUSTRIAL BLVD SW City: ATLANTA State: GA ZIP: 30336

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you: • Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage? ☐ Yes ■ No

If "Yes," indicate name of existing insurer:

Name:

If "Yes," are any Employees/Members on COBRA continuation? ☐ Yes ☐ No How many?

Do you intend to offer Employees/Members COBRA continuation? ☐ Yes ☐ No

II. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. PREMIUMS

Group's Premium Contribution for*: Employees/Members: 60 % Dependents: 60 %

Employee's/Member's Premium Contribution for: Employees/Members: 40 % Dependents: 40 %

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ☐ Yes ■ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ■ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: 200 Number Applying: _____

Number of Dependents: _____ Number of Retirees: 0

Are Domestic Partners covered under this Plan*? ■ Yes | No

Same Sex*? ■ Yes | No Opposite Sex*? ■ Yes | No

Dependent Children Covered to Age*: | 19 | 23 | ■ 26** | Other _____

Dependent Children Covered if Full-Time Student*? ■ Yes | No

If "Yes," Dependent Full-Time Students Covered to Age*: ■ 26 | 27 | Other _____

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

Eligibility Reporting Contact (produces the eligibility file): Zina Cooper

Address (if different from Group): _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____ Phone: ( ) _____ Fax: ( ) _____

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: Zina Cooper Phone: (470) 809-7722

Days/Hours of Availability: M-F 8 am- 5 pm E-mail Address: zina.cooper@cityofsouthfultonga.gov

PROBATIONARY PERIOD

For New Employees/Members: | 30 days | 60 days | 90 days | 180 days | ■ Other none

Probationary Period is waived for present Employees/Members: ■ Yes | No

Number of Employees/Members who have not yet completed the probationary period: 0

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of July 1, 20 17, provided all of the following have been completed prior to this effective date:

A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

The Group certifies that all the information shown on this application and any attachments are correct and complete as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated at: _____ this _____ day of _____, 20 __

Signed for the Group: ▶ _____ Title: MAYOR

VI. COMPANY DISPLAY NAME (Your Group name as it should appear to your employees)

Company Name CITY OF SOUTH FULTON GEORGIA
(Maximum of 30 characters, including punctuation and spacing.)

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

Broker's Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Contact: _____ Secondary Contact: _____

Title: _____ Title: _____

E-mail Address: _____ E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ Broker

Broker's Signature: ▶ _____

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

General Agent's Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Contact: _____ Secondary Contact: _____

Title: _____ Title: _____

E-mail Address: _____ E-mail Address: _____

Commission checks payable to: Firm General Agent

General Agent's Signature: ▶ _____